Philadelphia Inquirer - June 30, 2009
By Josh Goldstein

The doctor accused of giving the wrong radiation dose to dozens of prostate-cancer patients at the Philadelphia VA Medical Center defended himself yesterday for the first time, saying that many critics fail to understand the complexity of the treatments.

Just because patients didn't get the prescribed radiation dose doesn't mean their care was ineffective, University of Pennsylvania doctor Gary D. Kao told a U.S. Senate hearing in Philadelphia.

Kao admitted problems with the program and said he shared some blame, but "I am not willing to be the scapegoat for the complex, systematic problems."

He also said there was no definition of what constitutes a radiation-dosage mistake and when it should be reported.

But Steven Reynolds of the U.S. Nuclear Regulatory Commission disputed Kao's testimony, saying that the agency had long required reports when the dose is more than 20 percent off from what the doctor prescribed. And errant seed placement - which Kao contended is commonplace - is in fact rare in other programs, Reynolds said.

"Dr. Kao is mistaken," Reynolds said.

Kao stopped treating patients at both the VA hospital and Penn last year after concerns were raised that 114 patients might have received the wrong doses of tiny radioactive seeds intended to destroy prostate-cancer cells.

The doctor continued his National Institutes of Health-funded research at his Penn laboratory until taking a leave of absence last week.

At yesterday's hearing of the U.S. Senate Veterans Affairs Committee, Kao was confronted in person by the Rev. Ricardo Flippin, now of Charleston, W. Va., one of his patients injured by the treatment in 2005.

It was the first time the two had talked, Flippin said.

While Kao did not apologize, he publicly told Flippin that he wished he had done better, and the 68-year-old minister then embraced his onetime doctor.

Medical records of Flippin, a teacher and 21-year Air Force veteran who served in Vietnam, show that his prostate gland received only 67 percent of the radiation dose that had been prescribed.

"Until I received notification from the VA in Philadelphia [last year] that they were investigating my medical care . . . no one ever told me that there had been any problem with the procedure," Flippin said in his testimony. "That letter never mentions that other parts of my body apparently got a radiation dose greater than my doctor intended."

After the treatment, however, Flippin developed rectal pain, bleeding, and digestive problems that became debilitating.
A doctor outside the VA health system diagnosed Flippin's problem as radiation injury to the anal canal. Surgery repaired the damage, but he continues to have problems with bowel control.

Flippin's lawyer, W. Robb Graham of Cinnaminson, has filed a claim against the VA.

In June 2008, soon after learning that there might be a problem, the VA hospital suspended its brachytherapy program and contacted the affected veterans.

In brachytherapy, physicians permanently implant in a prostate from 80 to 120 tiny metal seeds that emit radiation over a 10-month period.

If improperly placed, the seeds can damage nearby organs while delivering less-than-optimal doses of radiation to the prostate.
The investigations into the brachytherapy program at the Philadelphia VA found that 57 of the patients were underdosed from February 2002 to June 2008.

An additional 35 patients got too much radiation to nearby tissues and organs, including 25 whose rectums received potentially dangerous doses.

Although Kao and the Department of Veterans Affairs have been in the spotlight over the suspended program, the controversy and investigations the case has spawned have implications for Penn as well.

The Philadelphia VA hospital is on the edge of the Penn campus, and the agency contracted with Penn physicians, who performed the brachytherapy procedures on veterans. The facility is also a teaching hospital for Penn medical residents.

Penn "continues to cooperate fully with the Veterans Administration in its ongoing review," said Susan E. Phillips, senior vice president at the Penn health system, in a statement. "We share the [VA's] goal of assuring that veterans receive the best possible care and believe that a thorough review is critical to achieving this goal."

Yesterday, Penn declined to comment further because of the ongoing investigations.

Gerald M. Cross, acting undersecretary for health at the VA, said that the agency's Philadelphia hospital and Penn had a "unique" relationship.

"In my review of this program, it is almost indistinguishable as to where the university ends and the VA begins," Cross said.

Still, Cross noted that the ultimate responsibility for quality control was the VA's.

"Regardless of any such relationships, regardless of any such contracts, we, the VA, must prevail in having our oversight of this program and any other program," he said.

The VA and NRC probes are expected to be completed later this summer.

While Penn and the Philadelphia VA hospital are under scrutiny, Kao remains at the center of the storm. Yesterday he made a brief opening statement and took questions from U.S. Sen. Arlen Specter (D., Pa.), a member of the VA committee, as well as U.S. Reps. Chaka Fattah (D., Pa.) and John Adler (D., N.J.).

In his written statement, Kao made a 14-point defense maintaining that the entire "multidisciplinary" team administering brachytherapy at the VA was well trained, that he never ordered seeds of the wrong strength, and that "inflammatory statements and actions" were falsely attributed to him.

"Never in my career have I falsified any medical records, and never have I participated in a cover-up," Kao said yesterday. "Contrary to the allegations that I was a 'rogue' physician, there were precise standard operating procedures formulated and a system of monitoring and oversight."